DHCFP INET USER AGREEMENT
Other Provider

As an employee of _____
(if more than one entity is applicable please attach and submit a list of all entities with this Agreement)

OR as an employee of a contractor of _____
(if more than one entity is applicable please attach and submit a list of all entities with this Agreement)

I will be allowed to access DHCFP-INET, the data reporting system provided to

_____ by the Division of Health Care Finance and Policy.

- I promise that I will not disclose my DHCFP-INET user ID and password to any other person.
- I promise that I will not attempt to access or look at DHCFP-INET data other than what is required to perform my job.
- I promise that I will use any data I receive from DHCFP-INET only as permitted and only in furtherance of my job.
- I promise that I will not share any data I receive from DHCFP-INET with others unless doing so is necessary to do my job (pertains to patient level confidential data only).
- I promise that I will discuss data I receive from DHCFP-INET with others only as required to perform my job and will conduct such conversations only in secure areas where I am unlikely to be overheard (pertains to patient level confidential data only).
- I promise I will not disclose any data that I receive from DHCFP-INET to any third party unless I have specific written permission from my supervisor or the legal order of a court (pertains to patient level confidential data only).
- I understand that the Division of Health Care Finance and Policy retains ownership of all data that resides in DHCFP-INET.
- I hereby acknowledge I have read the above terms and conditions and agree to be bound thereby as a condition of access to and use of DHCFP-INET.

REQUIRED INFORMATION – please print and no abbreviations

☐ Mr. ☐ Ms.
☐ Mrs. ☐ Dr. Name: _____
(Please provide middle name initial)

Job Title: _____

Company Name and Department: _____

Work Mailing Address: _____

_____

E-mail Address: _____
(Required to send User ID and Password information)

Work Telephone: _____

Work Fax: _____

User Signature: _____ Date: _____

ORGANIZATION(S) PROVIDER TYPE

Please specify your organization(s) provider type:

_____

(if more than one entity is applicable please attach and submit a list of all entities with this Agreement)

USER'S INET WEB SECURITY ITEMS – required

City or Town of Birth: _____

Pass Phrases: (please select a Pass Phrase below):

- ☐ Favorite Singer
- ☐ Favorite Vacation Location
- ☐ Favorite Sports Team
- ☐ Favorite Hobby
- ☐ Favorite Pet's Name
- ☐ Favorite Teacher's Name
- ☐ Anniversary Date
- ☐ Father's Middle Name
- ☐ First Child's Middle Name
- ☐ Make, Model, and Year of First Car

Pass Phrase Answer: _____

Pass phrases are used by the Help Desk staff to ensure they are speaking with the correct person.

When an INET User calls for assistance and requires using confidential information or sensitive issues, the Help Desk will use pass phrases as a means to confirm the identity of the caller.

Check the type of access for this User Agreement

User Profile (check one)	Functions
☐ Data Reporter's INET Administrator	The person responsible for the DHCFP-INET Administration (creates and maintains web user accounts online and via paper forms.) Also has the ability to: submit information, download, edit, view and print reports.
☐ Data Reporter's Individual INET User	Ability to: submit information, download, edit, view and print reports

Provider Submissions - Only check the submissions that User will submit or have access to under this Agreement

- ☐ Adult Day Health (ADH) Cost Report Submission
- ☐ Adult Foster Care (AFC) Cost Report Submission
- ☐ Ambulance Cost Report Submission
- ☐ Day Habilitation Program Supplemental Survey
- ☐ Student Health Insurance Plan (SHP) Information
- ☐ Patient Centered Medical Health Initiative (PCMHI) Efficiency and Cost Reports
- ☐ Health Safety Net (HSN) PCMHI Patient Reports
- ☐ Health Safety Net (HSN) PCMHI Payment Remittance